

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185165</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/01/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - CAMELOT</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 LYNDON LANE</b> <b>LOUISVILLE, KY 40222</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  Amended  An abbreviated survey was initiated on 09/30/14 and concluded on 10/01/14 for KY22291. The allegation was determined to be unsubstantiated, however, during the course of the investigation the facility was found to not meet the minimum requirements and a deficiency was cited.			F 000			
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.			F 225			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/17/2014

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185165</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/01/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - CAMELOT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 LYNDON LANE</b> <b>LOUISVILLE, KY 40222</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of personnel files, employee work assignments, the facility's policies for Prevention of Abuse and Background Investigations, Employee Criminal Court Records, and the Golden Living Eligibility Module, it was determined the facility hired one (1) of five (5) sampled applicants, who had been convicted of felony and misdemeanor crimes.</p> <p>The findings include:</p> <p>Review of the facility's policy for Prevention of Abuse, undated, revealed the facility screened applicants by conducting a criminal background check.</p> <p>Review of the facility's policy for Prevention of Abuse and Background Investigations, dated 03/01/2013, revealed a prospective new hire would have a background investigation that included a criminal conviction review. Certain criminal records would be an automatic bar to employment. Applicants with felony convictions during the last seven (7) years would not be eligible for employment. Applicants with misdemeanor criminal convictions during the last</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185165</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/01/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - CAMELOT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 LYNDON LANE</b> <b>LOUISVILLE, KY 40222</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 2</p> <p>three (3) years would not automatically be barred from employment. The most common examples of criminal convictions (felony records), which would result in refusal to hire include the following: burglary; sex crimes; theft; shoplifting; assault; welfare fraud; and, drug-related charges. The most common examples of criminal convictions (misdemeanor records), which may result in refusal to hire include the following: assault; drug-related charges; forgery; battery, domestic violence; theft; bad checks, and terroristic threatening.</p> <p>Review of the Golden Living (the company) Eligibility Module, revealed the company provided a listing to the facility of eligible applicants for hire.</p> <p>Review of the facility's personnel files, revealed Employee #2 was hired by the facility on 09/11/14 as a Certified Nurse Aide (CNA). The employee's criminal records report, dated 09/02/14, revealed a misdemeanor conviction for Criminal Possession of a Forged Instrument in 1994. No information on the sentence was located. In 1996, the employee was convicted on a felony charge for three (3) counts of Welfare Fraud. The sentence included one (1) year in prison (suspended), five (5) years of supervised probation, and court costs.</p> <p>Interview with the Director of Nursing (DON), on 10/01/14 at 1:45 PM, revealed Employee #2 was assigned to work as a CNA on the East Unit on the night shift, and A and B units on various shifts.</p> <p>Interview with the Administrator, on 10/01/14 at 9:12 AM, revealed the facility policy on</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185165</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/01/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - CAMELOT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 LYNDON LANE</b> <b>LOUISVILLE, KY 40222</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 3</p> <p>background investigations was the company's policy and effective company wide. Continued interview at 11:40 AM, revealed the background investigation was completed by the company after which the facility received the Golden Living Eligibility Module. He stated this module provided information to the facility regarding an applicant's eligibility for hire. He indicated this module was a recommendation/determination from the company and the facility followed the instructions on the report. He stated the report indicated to the facility to hire "yes" or not to hire "no". He stated the criminal court records do not come to the facility until later. He stated the company policy allowed applicants to be hired if there were no felony convictions in the last seven years and no misdemeanor convictions in the last three years.</p> <p>Interview with the Director of Clinical Education, on 10/01/14 at 12:15 PM, revealed the Golden Living Eligibility Module was received by the facility and indicated if the applicant was eligible for hire. She stated the company policy on felony and misdemeanor convictions did not allow for the facility to deny the hiring of an eligible applicant.</p>	F 225			